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Medicaid Management Information System (MMIS) and Fiscal Agent Services

Request for Information (RFI)

Issued by:

The State of Missouri
Department of Social Services
MO HealthNet Division

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Responses are requested by:

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Responses are to be submitted to:

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1.0 INTRODUCTION AND PURPOSE

1.1 Introduction

The Missouri Department of Social Services ("Department") is the designated State Medicaid Agency (SMA), and the MO HealthNet Division (MHD) of the Department is responsible for administering the Missouri Medicaid Program, known as *MO HealthNet*. Medicaid is a federal and state entitlement program that provides funding for medical benefits to low-income individuals who have inadequate or no health insurance coverage. Medicaid guarantees coverage for basic health and long term care (LTC) services based upon income and/or resources.

The Missouri Medicaid Enterprise (MME) is composed of the following State Agencies:

- The Family Services and Children's Divisions of the Department are responsible for the Medicaid participant eligibility and enrollment functions.
- The Missouri Medicaid Audit and Compliance (MMAC) Division of the Department of Social Services is responsible for the Medicaid provider enrollment and program integrity functions.
- The Division of Finance and Administration Services (DFAS) of the Department is responsible for providing administrative support for MHD including Medicaid payment processing and financial reporting.
- The Division of Legal Services of the Department is responsible for all the legal services related to the Medicaid program.
- The Information Technology Services Division (ITSD) of the Office of Administration is responsible for the development and operation of systems related to the Medicaid program.
- The Missouri Department of Mental Health (DMH) is responsible for administering Medicaid waiver programs.
- The Missouri Department of Health and Senior Services (DHSS) is responsible for administering Medicaid waiver programs.

Created as Title XIX of the Social Security Act in 1965, Medicaid is administered at the federal level by the Centers for Medicare & Medicaid Services (CMS) within the United States Department of Health and Human Services (HHS). CMS establishes and monitors certain requirements concerning funding, eligibility standards, and quality and scope of medical services. States have the flexibility to determine some aspects of their own programs, such as setting provider reimbursement rates and the broadening of the eligibility requirements and benefits offered within certain federal parameters.

1.2 Purpose of Request for Information

Missouri is currently planning for procurement for its Medicaid Management Information System (MMIS) and its Fiscal Agent services. This Request for Information (RFI) is issued for the purpose of obtaining information to support development of a procurement approach for consideration by MHD in preparing one or more Requests for Proposal (RFPs) to be awarded in one or more distinct contracts. MHD is seeking information regarding available MMIS solutions that would provide a comprehensive, scalable, and secure health care information system to support the program management needs of the Missouri Medicaid Enterprise (MME) for the next decade and beyond and Fiscal Agent (FA) services to

assist with program administration. The MME is interested in MMIS solutions and FA services that would provide some or all of the following opportunities:

- Reduced overall cost of the MMIS operations and Fiscal Agent services
- Increased automation of Medicaid business processes, including prior authorization and pre-certification of participant services supporting advancement of business process maturity as defined in the Medicaid Information Technology Architecture (MITA) framework
- Continuation of Fiscal Agent services, including operation of call centers; development, operation, and support of the MMIS; data center hosting services; privacy and security management services; receipt and distribution of letters and operation of a mailroom; professional review services to support prior authorization of participant services; data entry; document imaging; and project management services, with the majority of these services provided by staff located in Missouri
- A MMIS solution(s) capable of meeting the needs of the MME for the next decade with a modern, scalable, configurable, and customizable technical architecture based on the Service Oriented Architecture (SOA) principles and compliant with the CMS Medicaid IT Supplement (MITS-11-01-V1.0) Enhanced Funding Requirements: Seven Conditions and Standards
- MMIS components deployed for other SMAs, allowing the MME the opportunity to collaborate with other SMAs on Medicaid Program initiatives and share development costs
- Configurable MMIS solution(s) that reduces development time for functionality and business process modifications required to support Medicaid Program changes
- MMIS solution(s) supporting multiple payers and benefit packages designed for multiple individual eligibility groups
- A business rules engine incorporated into the MMIS solution(s) that allows business users to create, view, modify, and test business rules applied to claims processing and other system functions
- A robust provider web portal, web services, and network connection options that allow Medicaid healthcare service providers to submit and manage claims and access necessary participant and provider information in an automated fashion
- Compliance with the X12 and NCPDP transaction standards and the Council for Affordable Quality Healthcare's (CAQH) Committee on Operating Rules for Information Exchange (CORE) Operating Rules governing the exchange of transactions and information to support service provision, claims processing, and payment
- A robust participant web portal that allows users to view claims history, verify services provided, and find Medicaid healthcare service providers
- Privacy and security services ensuring compliance with privacy and security laws, regulations, and industry best practices and aggressive management of security risks
- A MMIS solution(s) supporting the Integrating the Healthcare Enterprise (IHE) standards to facilitate interfaces with other state systems and with the statewide Health Information Network (HIN) to share Medicaid claims data and retrieve clinical data

- A MMIS solution(s) supporting the Missouri Healthcare Home Program and the case management and coordination of care business functions within the MME
- Effective data management to facilitate secure distribution of Medicaid claims data to other partners while ensuring timeliness, security, and data integrity

The MME anticipates MMIS solution(s) and Fiscal Agent services that take advantage of these opportunities will be valuable tools in managing the MME programs, providing services to program participants, and supporting the Medicaid healthcare service providers.

1.3 Vendor Demonstrations

As a result of the RFI response, the MHD may choose to have vendors demonstrate their solutions. The proposed timeframe for these demonstrations is currently November 17, 2014 through November 21, 2014 and December 1, 2014 through December 5, 2014. Formal invitations will be sent at a later date, once all responses have been received and reviewed.

2.0 Background and Current State

Proposed solutions will need to support the information needs of the various programs and populations across the MME. On an annual basis, the current MMIS processes over 95 million claims received from over 800 claims transaction submitters representing an average of over 8,000 providers in each payment cycle. To provide an understanding of program size, a summary of *MO HealthNet* statistics for State Fiscal Year (SFY) 2013 (June 2012 through June 2013) is provided below:

- On average, 879,344 people were enrolled in *MO HealthNet* each month.
- Percentage of enrollees:
  - 60.8% – Children
  - 18.6% – Persons With Disabilities
  - 12.0% – Pregnant Women & Custodial Parents
  - 8.6% – Seniors
- 273, 425 claims were processed daily, 99% of which were submitted electronically.
- *MO HealthNet* Expenditures – $7,079.4 M.
- Percentage of Expenditures:
  - 48.5% – Persons With Disabilities
  - 24.8% – Children
  - 17.9% – Seniors
  - 8.8% – Pregnant Women & Custodial Parents

The MHD is divided into four primary operational units: Program Operations, Information Systems, Finance, and Medical Services. The Program Operations unit includes Pharmacy Services, Clinical Services, Program Relations, Managed Care, and Waiver Programs. The Information Systems unit includes the MMIS and the Clinical Management Services and System for Pharmacy Claims and Prior Authorizations (CMSP). The Finance unit includes Financial Services and Reporting, Institutional Reimbursement, Waiver Financing, Rate Setting, Budget, Cost Recovery, Audit Services, Pharmacy Fiscal, and CMS Financial Reporting. The Medical Services unit includes Program Quality, Psychology, and Medical Services. All four units report to a Division Director and Deputy Division Director. MHD employs over 200 staff.

Key information regarding the Missouri Medicaid Program can be found at: http://dss.mo.gov/mhd/general/pages/about.htm.

2.1 Fiscal Agent Services

The MHD contracts with a Fiscal Agent to provide the following services related to the administration of the Missouri Medicaid Program:

- **Program Participant Call Center:** Respond to inquiries regarding eligibility, spenddown, and covered services and educate participants on services. Annual average of 200,000 calls and 2,500 pieces of correspondence were received in SFY 2012.
- **Provider Relations Call Center:** Respond to questions regarding program policies, assist providers with claims, educate providers regarding claims processing steps, and train providers. Averaging over 211,000 phone inquiries and 11,000 email inquiries in SFY 2012.
- **Clinical Services Call Center:** Assist providers with obtaining service authorization for drug and medical services and coordinate peer-to-peer reviews. Average of 400,000 pharmacy, medical, and psychology phone requests and more than 355,000 pharmacy phone requests and 40,000 pharmacy and psychology fax requests were processed in SFY 2012.
- **Technical Help Desk:** Provide all center services for State staff and healthcare service providers responding to issues related to the MMIS. Average of 18,000 help desk calls were answered in SFY 2012.
- **Mailroom Services:** Receive and distribute letters and packets. Over 400,000 paper artifacts received and processed in SFY 2012.
- **MMIS Operational Services:** Develop, operate, and maintain MMIS solutions for claims processing, pricing, payment, financial cycles, and federal financial reporting, State Medicaid Agency program administration, and provider web portal for claims management and eligibility verification.
- **Data Center Hosting Services:** Provide data center hosting services for MMIS solutions, with all data located in the United States.
- **Network Connection and Interface Services**: Maintain necessary secure network connections and interfaces to support exchange of data with the State, healthcare providers/clearing houses, and other entities.
- **Privacy and Security**: Provide Privacy and Security Officer and staff responsible for establishing policy; monitoring compliance with applicable laws, regulations, and industry best practices; managing user access; and training staff.
- **Project Management Office**: Provide a Project Management Office staffed with professional Project Managers to establish and support a formal project management methodology and Software Development Life Cycle (SDLC) and manage system enhancement and program modification projects.
- **Third Party Liability (TPL) Cost Avoidance:** Identify and verify TPL leads based on information supplies by program participants and update participant records. Annual average of 80,000 leads.

- **Medicaid Identification Cards:** Print and mail identification cards to program participants.
- **Data Entry and Imaging:** Process paper claims and attachments, image provider and participant correspondence, resolve suspended claims, and perform data entry into the MMIS. Over 300,000 paper claims, 22,000 prior authorization requests processed and keyed.
- **Provider Manuals:** Maintain the program provider manuals, including tracking of manual versions, approvals of manual modifications, and publishing of provider manuals on a web portal.
- **Enrollment Broker Services:** Perform recipient educational and outreach services, enrollment / disenrollment of eligible recipients into managed care organizations, data enter enrollment and updates into MMIS; receive and document recipient requests for change in Managed Care Organization (MCO); and respond to recipient inquiries and concerns regarding the enrollment process. During SFY 2012 the Enrollment Broker Service answered over 75,000 participant calls, mailed over 448,000 enrollment packets and over 215,000 program letters, and processed more than 22,000 pieces of mail.
- **Medical Policy:** Research, analyze, develop, and implement Medicaid and non-Medicaid program policy. Identify regulatory changes that require implementation in the MMIS and oversee MMIS to ensure processing in compliance with program policy. Average of 325,000 resolution claims resolved and over 428,000 medical policy claims reviewed.
- **Disaster Recovery:** Create, maintain, and execute a plan designed to minimize any disruption to the system or to ensure a resumption of the system following a disaster such as fire, flood, or tornado.
- **Quality Assurance:** Monitor operations to ensure compliance with State-specified performance requirements. Provide continuous workflow improvement in the overall system and contractor operations. Work with the State to identify quality improvement measures that will have a positive impact on the overall program.

The current Missouri MMIS Fiscal Agent is Wipro Infocrossing, Inc., who was awarded the FA contract in 2006. The current contract can be extended through June 30, 2017. The majority of services are provided by staff located in Jefferson City, Missouri.

2.2 Primary Systems

2.2.1 Medicaid Management Information System

MO HealthNet contracts with Wipro Infocrossing, Inc. for the development, operation, and maintenance of the MMIS, including the provider and MHD portals, claims processing, financial subsystem, and provider enrollment. The current Fiscal Agent contract with Wipro Infocrossing was awarded in 2006 and can be extended through June 30, 2017.

The current primary MMIS solution was implemented in 1979 and has been modified and enhanced numerous times to add new components and functionality. The most significant enhancements have been implemented since 2007. The MMIS core is a mainframe system. Web portals have been created to facilitate system interactions for State staff and providers. Providers submit either electronic HIPAA-compliant Electronic Data Interchange (EDI) transactions or direct data entry through a web portal or paper claims. Approximately 99% of all claims are submitted electronically. Paper claims are scanned or manually entered into the MMIS. Once claims are in the MMIS, various batch processes and jobs are

used to complete the claims adjudication, payment, and other processes. On an annual basis, the current MMIS processes over 95 million claims received from over 800 claims transactions submitters, representing an average of over 8,000 providers in each payment cycle.

Most recently, the current MMIS contract included 19 separate enhancements to the MMIS, including migration to a relational database and implementation of a rules engine. These enhancements have lengthened the useful life of the existing system, but additional enhancements are needed to create a system capable of meeting conditions and requirements established by the CMS.

The primary MMIS functions are as follows:

- **Claims Processing:** Point of Sale (POS) and real-time claims processing, pricing, application of prior authorization and pre certification rules, payment, mass adjustment, and federal financial reporting for all claim types. On average over 100 million claims annually, with over 90% Fee for Service (FFS).
- **Participant Benefit Management:** Configuration and management of different benefit packages for numerous participant groups. Current MMIS supports over 30 adult and over 30 children medical eligibility codes across 40 MO HealthNet covered services.
- **Multi-Payer Program Management:** Management of claims processing for multiple, separate payers with different funding sources and program policies.
- **Managed Care Program Management**: Processing of capitation payments and encounter claims for participants enrolled in a Managed Care Program and FFS carve outs of specified benefits (e.g., pharmacy). MO HealthNet managed care currently supports up to nine different Health Plans, spanning 3 regions and 54 counties.
- **Program Financial Management:** Management of program financials, including tracking of payments by funding source, accounts receivable, and manual payouts. In SFY 2012 MO HealthNet adjudicated over $6 billion in payments to over 45,000 active and eligible providers.
- **Participant Eligibility Management:** Tracking of participant eligibility, including tracking of participant spenddown, payment of premiums, provider lock-in, point-in-time eligibility history, multiple benefit eligibility, and the hierarchies to support multiple lock-ins and eligibility**.** As of 1/1/2014, 839,335 participants were enrolled in MO HealthNet. Out of that 419,115 participants were enrolled in FFS program, while 420,220 were enrolled in Managed Care.
- **Healthcare Service Provider Management:** Tracking of enrolled healthcare service providers by provider type and specialty codes. The MMIS currently manages over 48,000 active providers across 57 different provider types.
- **Third Party Liability Collection:** Tracking of third party liability leads, generation of invoices to insurance companies based on paid claims, and tracking of payments. In SFY 2012 over 82,000 TPL leads were completed.
- **Rules Engine:** Rules engine allowing business users to apply program policy to the processing of claims and payments through view, creation, modification, and testing of rules and edits applied to processing. The current MMIS supports over 2000 distinct rules across the following adjudication areas: validation, provider, participant, and final adjudication rules. The MHD is currently

implementing rules for TPL letters, and edits for pricing, history, prior authorization and attachments. Implementation is slated for June 30, 2016.

- **Program Metrics and Dashboards:** Dashboards and metrics allowing program staff to monitor and manage the Medicaid Program.
- **Privacy and Security:** Application of Privacy and Security laws, regulations, and best practices.
- **Clinical and Pharmacy Edits:** Application of clinical and pharmacy edits to claims at the Point of Sale (POS) or during real-time adjudication. As of May 2014 54% of claims have been processed in real time through the POS system.
- **Pharmacy Claims Pricing:** Pricing pharmacy claims based on multi-tiered pricing schedules and complex rules.
- **Drug Rebate:** Identification of pharmacy claims subject to drug rebate, generation of invoices to pharmaceutical companies, and tracking of drug rebate payments.
- **340B Pharmacy Claims Pricing:** Identification of pharmacy claims subject to 340B pricing with a separate pricing structure.
- **Program Integrity:** Functions such as Provider on review, lock-in verification, applying limit criteria and contra-indicated criteria, pattern identification, claim denials, claim suspensions, or any functionality that leads to improvements in the Medicaid program or the detection and correction of misuse and abuse of the program.
- **Interactive Voice Response System:** Automated solution for use by program participants and healthcare service providers to obtain information by phone regarding participant eligibility and covered services.
- **Fax Tracking:** Automated solution for receiving faxes from healthcare service providers, routing the fax to the appropriate business user, and maintaining an archive of the faxed documents.
- **Ad-hoc Reporting:** Ad-hoc business reports used for decision-making generated from claims and eligibility information.
- **Non-Emergency Medical Transportation:** Reimbursement for the use of Non-Emergency Medical Transportation for health care appointments. Ability to accept encounter claims and provide monthly capitation payments for NEMT providers on a regional, statewide, or FFS basis.
- **Workflow Management:** Automated workflow management solution(s) for tracking and sharing tasks and documents; imaging and tracking correspondence received from participants, providers, government officials, and the public and responses from the State or Fiscal Agent; and tracking approvals applied to program policy changes and MMIS system task requests. Solution(s) to be used by the State and Fiscal Agent.
- **System Issue and Modification Ticket Tracking System:** Automated solution for tracking issues reported by system users and requests for system modifications. System will track tickets to resolution and implementation.

2.2.2 Clinical Management Services and System for Pharmacy Claims and Prior Authorization (CMSP)

In 2001, the MHD committed to the development of a supplemental MMIS solution referred to as the Clinical Management Services and System for Pharmacy Claims and Prior Authorization (CMSP) to automate clinical editing and prior authorizations of services provided to Medicaid participants. Subsequently, the CMSP solution was expanded to provide a web portal allowing providers to view Medicaid claims and support coordination of care within the Missouri Medicaid Program. The CMSP solution has also been expanded to provide a solution for managing the Missouri Medicaid Electronic Health Record Incentive Program. This is a separate system and services contract from the MMIS, and the CMSP contract is maintained and supported by Xerox Heritage, LLC. This contract can be extended through June 30, 2017.

The primary functions of the CMSP contract are as follows:

- **Automated Prior Authorization and Pre Certification Services:** Provide an automated determination of prior authorization and pre certification of services provided to program participants based on program policies, historical claims data, and clinical information provided by the healthcare service provider. In the month of August, 2014 the following prior authorization and pre-certification services were performed:
  - Submitted over 13,600 medical pre-certifications
  - Checked over 40,000 medical rules
  - Created over 2,600 Durable Medical Equipment (DME) pre-certifications
  - Processed over 27,000 imaging, 16,000 psychology, and 8,500 optical prior authorizations
  - Exchanged prior authorization requests and responses for over 200,000 Point of Sale pharmacy claims per day
- **Professional Review Services:** Provide review services for prior authorization and pre certification of services provided to program participants to determine medical necessity and program coverage and coordinate peer-to-peer reviews with professional review staff.
- **Provider Web Portal:** Provide web-based, HIPAA-compliant portal (system) for providers and/or their authorized staff to access patient claim information and to electronically request a prior authorization (PA) and/or pre-certification. In August, 2014 over 64,000 patient history checks were performed.
- **Health Information Exchange (HIE):** Process Continuity of Care Documents to support exchange of clinical information with a health information network.
- **Medication Therapy Management and Immunization Billing:** Process Medication Therapy Management and Immunization Billing that allows pharmacies to submit Medical 837 transactions for billing.
- **Drug Formulary:** Maintain a drug formulary with regular automated and manual updates, publish the drug formulary for healthcare service providers, and apply the formulary to claims processing.
- **Rules Engine:** Provide a rules engine that allows business users to apply program policy to the processing of prior authorization and pre-certification through view, creation, modification, and

testing of rules and edits applied to processing. Over 200 pharmacy rules are used to systematically process over 90% of pharmacy claims without requiring manual intervention.

- **Drug Utilization Review (DUR):** Provide comprehensive prospective DUR (proDUR) and retrospective applications to work in conjunction with the pharmacy claims adjudication process performed by the Fiscal Agent to screen pharmacy claims for clinical issues prior to and post payment.
- **Prescription Price Compare:** Allow the public access to the average price within that locality of the State when purchased from a Missouri Medicaid participating provider. Provide the ability to perform queries based on area code, zip code, specific store, county, or city and for specific drugs by the specific trade, generic and/or chemical name, and strength. Make available drug educational materials. Over 300 drug comparison queries are submitted each month.
- **E.H.R. Incentive State Level Registry (SLR) Web Portal:** Provide a Provider facing application that allows hospitals and providers to register, attest, and receive payments under Missouri's E.H.R. Provider Incentive Program as specified by CMS. The application also provides functions to validate and approve or reject submitted attestations for payment.
- **Home and Community Based Services (HCBS):** Provide opportunities for Medicaid beneficiaries to receive services in their own home or community. These programs serve a variety of targeted populations groups, such as people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities.
- **Health Home Verification and Reporting:** Provide a service that allows Health Home service providers to report quality measures to the State. MHD is also required to report utilization, expenditure and quality data for an interim survey and an independent evaluation.
- **Help Desk:** Provide call center services for State staff and healthcare service providers responding to issues related to CMSP functions. On average over 15,000 helpdesk transaction are received per month. Over 11,000 claims were approved and over 3,300 claims were denied in August 2014.

Xerox supports approximately 18,500 users across the various functions listed above. Over 110,000 user logins were encountered during August, 2014.

2.2.3 Missouri Eligibility Determination and Enrollment System (MEDES)

In 2013, the MHD committed to the provision and implementation of a comprehensive, fully integrated, state-of-the-art automated human services eligibility, enrollment, and case management system. MEDES is currently in design, development, and implementation (DDI), with multiple phases scheduled to complete by December 31, 2015. The current and future MMIS will be required to interface with the MEDES application.

The functionality includes, but is not limited to:

- Appeals Management
- Premiums Invoicing and Collections
- Plan Management for Managed Care
- Managed Care Plan Enrollment
- Claims and Restitution

- Participant Eligibility
- Citizen Web Portal
- State and Federal Exchange

The new MMIS will need to interface with the MEDES application in order to send and receive applicable data needed to support claims adjudication and participant information such as eligibility inquiries.

2.2.4 Provider Management and Program Integrity System

On April 30, 2014 Digital Harbor was awarded the contract to develop a new Provider Management and Program Integrity Case Management System. The project is currently in the DDI phase, with an implementation scheduled for the second quarter of 2015.

The MMIS will need to interface with this solution to support the exchange of provider enrollment information and claims data. A provider master table will be maintained in the MMIS to support claims processing and will receive updated provider information from the Provider Management System, but all provider enrollment functions will be managed by the Provider Management System.

2.3 Federally Mandated Program Changes

Missouri currently has many federal and state initiatives within the MME. Some of the projects are federally mandated, while others are enhancements to systems and projects to improve the MMIS and its programs. The following federal program changes have either been implemented recently or are currently active projects:

- **X12 5010 and NCPDP D.0** initiative mandated by HIPAA introduced the new transactions standards for the following versions adopted by HHS: ASC X12 Version 5010, and NCPDP Versions D.0 and 3.0. These standard changes were managed in two phases, with the final phase being implemented in April of 2013. All formats used were upgraded from X12 Version 4010A1 to 5010 and from NCPDP 5.1 to D.0.

- **ICD-10** required changes to the MMIS to accommodate the processing of claims using the International Classification of Diseases, 10th Edition (ICD-10) diagnosis codes, and procedures codes. In October 2013, MHD successfully modified and implemented these changes to the MMIS. CMS has mandated an October 2015 go-live date for all states to be compliant. Until then MHD continues to work with the provider community providing education and testing to support this mandate.

- **CORE Operating Rules:** The Council for Affordable Quality Healthcare (CAQH) launched the Committee on Operating Rules for Information Exchange (CORE) with the vision of giving providers access to eligibility and benefits information before or at the time of service using the electronic system of their choice for any patient or health plan.

  There are four ACA-mandated operating rules. Missouri has implemented the first three and is currently seeking certification of compliance with the CORE Operating Rules Phases I-III. This compliance requires successful implementation and testing of the CORE phases I-III and X12 5010 and NCPDP D.0 transactions. Certification is required by December 31, 2015.

MHD is waiting on the definition of CORE Rules for Phase IV. Once the rules have been released, MHD will determine the impact of the rules to business processes, rules, and logic to determine the design, development, implementation (DDI) changes, and effort. In the meantime, MHD is actively participating in WEDI forums, CMS discussions, and any activity that will help prepare them for the release.

- **Transformed Medicaid Statistical Information System (T-MSIS)** is an update to the existing Medicaid and Statistical Information System (MSIS) used by CMS to gather key eligibility, enrollment, program, utilization, and expenditure data for the Medicaid and Children's Health Insurance Program (CHIP). This data provides CMS with a large-scale database of eligibles receiving services under Medicaid and CHIP programs for every state and territory.

  MSIS requires states to provide CMS with quarterly updates containing specified data elements for eligible Medicaid participants and paid adjudicated claims for medical services reimbursed with Title XIX funds.

  T-MSIS will require states to submit eight files monthly in addition to the five MSIS files currently submitted, and expand data elements from 400 to 1,000 collected. The mandate added Provider, TPL, and Managed Care files.

  MHD is in the final stages of development with a planned implementation of October 2014.

The new MMIS for the State must remain compliant of these initiatives as well as any future initiatives that may be mandated by CMS.

2.4 HITECH

2.4.1 Health Information Network (HIN)

Missouri has created a statewide Health Information Network (HIN) that will ensure patients, providers, physicians, hospitals, and other health care organizations have access to critical medical record information in order to improve patient care and public health. This is a key part of Electronic Health Record (EHR) adoption and achieving the goals of the Health Information Technology for Economic and Clinical Health (HITECH) Act.

The HIN supports secure exchange of health information between authorized stakeholders in the healthcare community. It will improve the delivery of patient care by removing the communication barriers between the stakeholders with a single sign on access to patient data. Missouri has built a statewide HIN in order to:

- Improve the quality of medical decision-making and the coordination of care
- Provide accountability in safeguarding the privacy and security of medical information
- Reduce preventable medical errors and avoid duplication of treatment
- Improve the public health
- Enhance the affordability and value of health care
- Empower Missourians to take a more active role in their own health care

This is a current project within the MME and is being implemented in three phases:

- **Phase 1**. Outgoing Medicaid claims data for response to patient query, implemented in 1st quarter 2014
- **Phase 2**. Initiating patient query to view clinical data, in process
- **Phase 3**. Consuming clinical data into the CMSP

Planning, including requirements definition and design, has already started for Phase 2.

2.4.2 Electronic Health Record Incentive State Level Registry

The Medicaid EHR Incentive Program provides financial incentives for the adoption and 'meaningful use' of certified EHR technology to eligible professionals and hospitals. The purpose of the program is to encourage widespread adoption of EHR technology to improve patient care.

To receive EHR incentive payments, providers must show that they have adopted, implemented or upgraded to certified EHR technology in the first year and demonstrate that they are 'meaningfully using' their EHRs in subsequent years. Eligible professionals participate in the program on the calendar year, while eligible hospitals participate based on the federal fiscal year.

CMS establishes the thresholds and definitions for 'meaningful use, which is a phased approach divided into three stages with increasing requirements for participation. Stage 1 measures focus on data capture and sharing; Stage 2, advanced clinical processes and Stage 3, improved outcomes.

Missouri's Medicaid EHR incentive program is supported by a State Level Registry, a separate secure portal with these functions:

- Accepts and stores all attestation information from eligible providers for multiple years, including role based screens that capture demographic information, eligibility data, certified EHR systems, meaningful use data, and payment history.
- Receives and provides data to the CMS Registration and Attestation System according to CMS interface specifications to meet program reporting requirements for registrations, payments, audits and appeals.
- Offers timely updates to meet changing requirements for meaningful use stages and objectives issued in a series of CMS rules.

The future MMIS solution will be required to maintain the interfaces associated with both the EHR and the HIN. Future phases may be necessary to maintain compliancy.

3.0 VISION/FUTURE STATE

The MME envisions a MMIS solution(s) that will provide a comprehensive, scalable, and secure health care information system to support the program management needs of the MME for the next decade and beyond and continuation of Fiscal Agent services to assist with program administration. Results of the recently completed Medicaid Information Technology Architecture (MITA) Framework 3.0 State Self-Assessment (SS-A) indicate that MHD is targeting Level 2 and Level 3 MITA maturity for the functions supported by current MMIS solutions. The MME will need a focus on automation, standard data models, standard business rules, and collaboration with data trading partners to meet the target business process maturity levels.

As described in Section 1.2, MHD is gathering information regarding available MMIS solutions to serve as valuable tools in support of key business functions, including claims processing, management of the Managed Care Program, participant benefits management, financial management, and provider management. While meeting time, funding, and resource constraints, the MME is interested in looking at CMS-certifiable MMIS solution alternatives including the following:

- Commercial Off-the-Shelf (COTS) or federal/state-owned "complete" solutions providing most or all MMIS functions
- Solutions built from "Best of Breed" business function modules and technical components
- Solutions utilizing services shared with other State Medicaid Agencies

MME goals and objectives for an MMIS solution (s) and Fiscal Agent services of the future might include the following:

- Reduced overall cost of the MMIS operations and Fiscal Agent services.
- Increased automation of Medicaid business processes, including prior authorization and pre certification of participant services, that advance business process maturity as defined in the Medicaid Information Technology Architecture (MITA) framework
- Continued Fiscal Agent services, including operation of call centers; development, operation, and support of the MMIS; data center hosting services; privacy and security management services; receipt and distribution of letters and operation of a mailroom; professional review services to support prior authorization of participant services; data entry; document imaging; and project management services, with the majority of these services provided by staff located in Missouri
- MMIS solution(s) capable of meeting the needs of the MME for the next decade with a modern, scalable, configurable, and customizable technical architecture based on SOA principles and compliant with the CMS Medicaid IT Supplement (MITS-11-01-V1.0) Enhanced Funding Requirements: Seven Conditions and Standards
- MMIS components deployed for other State Medicaid Agencies (SMAs), allowing the MME the opportunity to collaborate with other SMAs on Medicaid Program initiatives and share development costs
- Configurable MMIS solution(s) that reduces development time for functionality and business process modifications required to support Medicaid Program changes
- MMIS solution(s) supporting multiple payers and benefit packages designed for multiple individual eligibility groups
- A business rules engine incorporated into the MMIS solution(s) that allows business users to create, view, modify, and test business rules applied to claims processing and other system functions
- A robust provider web portal, web services, and network connection options that allow Medicaid healthcare service providers to submit and manage claims and access necessary participant and provider information in an automated fashion
- Compliance with the X12 and NCPDP transaction standards and the Council for Affordable Quality Healthcare's (CAQH) Committee on Operating Rules for Information Exchange (CORE) Operating

Rules governing the exchange of transactions and information to support service provision, claims processing, and payment

- A robust participant web portal allowing users to view claims history, verify services provided, and find Medicaid healthcare service providers.
- Privacy and security services that ensure compliance with privacy and security laws, regulations, and industry best practices and aggressive management of security risks.
- MMIS solution(s) supporting the Integrating the Healthcare Enterprise (IHE) standards to facilitate interfaces with other State systems and with the statewide HIN to share Medicaid claims data and retrieve clinical data
- Effective data management to facilitate secure distribution of Medicaid claims data to other partners while ensuring timeliness, security, and data integrity

Additionally, a future MMIS solution(s) must meet all Medicaid Enterprise Certification Toolkit (MECT) checklist items for the DSS checklist, which can be accessed through the following link:

http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MMIS/Downloads/mectchecklist.zip

4.0 SUBMISSION REQUIREMENTS

This RFI is issued for the purpose of obtaining information to develop the strategy for the MMIS and fiscal agent services RFP(s). All interested vendors are requested to respond to the items outlined in Section 5.0, *Vendor Response*. All interested parties should submit their response to the RFI as outlined in section 4.1. This RFI does not constitute a solicitation of proposals, a commitment to conduct procurement, or an offer to contract or prospective contract.

The State of Missouri will not be liable for any costs incurred by respondents in the preparation and submission of information in responses to this RFI. All information received by the State becomes the property of State of Missouri and the Department of Social Services, MO HealthNet Division, and Office of Administration-Information Technology Services Division (OA-ITSD) and will not be returned to the vendor.

The MHD will acknowledge receipt of any responses. Acceptance of responses to this RFI places no obligations of any kind upon the State of Missouri. The descriptions presented in this RFI are tentative and may change prior to actual release of the RFP(s).

4.1 Response Submission, Date, Time, and Format

Respondents should submit one electronic copy of their response by email as an attachment to the MHD Designated Point of Contact no later than 5:00 PM CDT October 24, 2014. The electronic copy should include a Respondent Identification Cover Page, Organization Summary, completed Response Form in the provided excel spreadsheet format, and completed Response to RFI Questions.

Faxed responses or verbal inquiries will not be accepted. Respondents should submit any questions or comments regarding the RFI to the designated point of Contact no later than 5:00 PM CDT October 24, 2014.

4.2 Designated Point of Contact

The following address is the official point of contact regarding this RFI and the delivery point for all responses and correspondence:

Todd Meyer
MO HealthNet Division
615 Howerton Court
PO Box 6500
Jefferson City, MO 65102-6500
Phone: (573) 751-7996
Email: Todd.Meyer@dss.mo.gov

4.3 Public Information

All submitted responses to this RFI will be subject to Missouri's Sunshine Law and will be shared upon request or will be made publicly available on the State of Missouri website.

More information regarding the Missouri Sunshine Law can be found at http://ago.mo.gov/sunshinelaw/.

4.4 Disclaimers and Disclosure of Proposal Content and Proprietary Information

All information received from respondents becomes the property of the State of Missouri and the Department of Social Services (DSS), MO HealthNet Division (MHD), and Office of Administration-Information Technology Services Division (OA-ITSD). As such, RFI responses can be published in the public domain at the conclusion of the selection process. The State of Missouri does not guarantee protection of any information from public disclosure.

5.0 Vendor Response

All respondents to this RFI are requested to provide as much information as they can for the following sections of their response.

Item #	Section	Page Limit
5.1	Respondent Identification Cover Page	1
5.2	Organization Summary	3
5.3	Response Form	Form
5.4	Response to RFI Questions	20
5.5	Other Comments	3
	Total	27

5.1 Respondent Identification Cover Page

- Provide the vendor company name, mailing address, and phone number
- Provide the vendor contact name, email address, and phone number

- ~~Describe the vendor's potential involvement in working with the MMIS, fiscal agent operations, and/or the Missouri Medicaid program~~

- Please refer to Appendix A for a cover page template

5.2 Organization Summary

Respondents should provide a brief description of their organization, including the following:

- A general description of the primary business of the organization and its client base
- The organization's areas of specialization
- Any current or recent experience working with state Medicaid agencies
- Any experience operating as a fiscal agent for a state Medicaid agency
- Size of the organization, including structure
- Vendor support staff qualifications, including experience working with Medicaid systems and care management
- Length of time the organization has been in business, as well as how long the organization has been providing MMIS solutions

If you are collaborating with other organizations to complete your response, please be clear which organization is providing various modules or capabilities of the overall solution in your submitted response.

5.3 Response Form

In addition to the questions in section 5.4, the State requests that each respondent also fill out; 1) the MMIS functions tab, and 2) the Fiscal Agent Services tab for the **MO_MMIS_RFI_Fiscal_Agent_Response_Form.xls** that accompanies this RFI document.

5.4 Response to RFI Questions

The State of Missouri requests each respondent to provide responses to the following questions regarding their MMIS Solution:

Please indicate the products and/or services that your organization is interested in and capable of providing as the primary contractor. Subcontractors may be utilized to provide products and services. Check all that apply.

☐ Fiscal Agent Services in Missouri including the following:

- Call center services for program participants and healthcare service providers with the call centers located in Missouri.
- Mailroom services for receipt and distribution of letters and packets with mailroom located in Missouri.

- Professional review services for prior authorization and pre certification of services provided to program participants with professional review staff located in Missouri.
- Third Party Liability (TPL) Cost Avoidance services including identifying and verifying TPL leads based on information supplies by program participants and updating participant records.
- Printing of Medicaid ID cards and mailing to program participants.
- Process paper claims and attachments, image provider and participant correspondence, resolution of suspended claims, and data entry into the MMIS.
- Maintenance of the program provider manuals including tracking of manual versions and approvals of manual modifications and publishing of provider manuals on a web portal.
- Activities related to research, analysis, development and implementation and management of Medicaid and non-Medicaid program policy. The business area also identifies regulatory changes that require implementation in the MMIS and oversee MMIS to ensure processing in compliance with program policy.

☐ Development, operation, and maintenance of a MMIS solution(s) for claims processing, pricing, payment, financial cycles, and federal financial reporting, State Medicaid Agency program administration, and provider web portal for claims management and eligibility verification with most staff located in Missouri.

☐ Data Center Hosting Services for MMIS solutions including maintenance of necessary secure network connections and interfaces to support exchange of data with the State, healthcare providers/clearing houses, and other entities with all data located in the United States.

☐ Call Center Services for program participants and healthcare service providers with the call centers located in Missouri.

☐ Automated Solutions and Professional Review Services for Prior Authorization and Pre Certification of services provided to program participants including inpatient, option, Durable Medical Equipment (DME), imaging, and psychology services with professional review staff located in Missouri.

☐ System Integrator services to provide the necessary hardware and software and manage the implementation of a replacement MMIS solution(s) with turnover of the MMIS solution(s) to a Fiscal Agent and/or the State at the completion of the implementation and with most staff located in Missouri.

☐ MMIS Solution capable of administering a State Medicaid Program and performing the following functions

- Point of Sale (POS) and real-time claims processing, pricing, application of prior authorization and pre certification rules, payment, mass adjustment, and federal financial reporting for all claim types.
- Configuration and management of different benefit packages for numerous participant groups.
- Management of claims processing for multiple, separate payers with different funding sources and program policies.

- Processing of capitation payments and encounter claims for participants enrolled in a Managed Care Program.
- Program financials including tracking of payments by funding source, accounts receivable, and manual payouts.
- Tracking of participant eligibility including tracking of participant spenddown and premium payments.
- Tracking of enrolled providers by provider type and specialty codes.
- Third party liability collections.
- Rules engine allowing business users to apply program policy to the processing of claims and payments through view, creation, modification, and testing of rules and edits applied to processing.
- Dash boards and metrics allowing program staff to monitor and manage the Medicaid Program.
- Application of Privacy and Security laws, regulations, and best practices.

☐ MMIS Solution capable of administering the clinical and pharmacy aspects of a State Medicaid Program and performing the following functions:

- Application of clinical and pharmacy edits to claims at the Point of Sale (POS) or during real-timem adjudication.
- Maintaining a drug formulary.
- Pricing pharmacy claims based on multi-tiered pricing schedules and complex rules.
- Identification of pharmacy claims subject to drug rebate, generation of invoices to pharmaceutical companies, and tracking of drug rebate payments.
- Identification of pharmacy claims subject to 340B pricing.
- Providing a web portal for use by healthcare providers with access to the claims history for program participants, calculation of the medication possession ratio, and explanation of rules applied during claims processing.
- Processing of Continuity of Care Documents to support exchange of clinical information with a health information network.
- Processing of Medication Therapy Management and Immunization Billing that allows pharmacies to submit Medical 837 transactions for billing.

☐ Development, Operation, and Maintenance of the Legacy Missouri CICS Mainframe MMIS during a period of transition to a replacement MMIS including hosting and maintenance of necessary secure network connections and interfaces to support exchange of data with the State, healthcare providers/clearing houses, and other entities with all data located in the United States.

☐ Development, operation, and maintenance of the legacy Missouri CICS Mainframe MMIS for the next decade including hosting and maintenance of necessary secure network connections and interfaces to support exchange of data with the State, healthcare providers/clearing houses, and other entities with all data located in the United States. Implementing enhancements to the legacy MMIS to replace remaining COBOL modules and implement a modern technical architecture compliant with the CMS Medicaid IT Supplement (MITS-11-01-V1.0) Enhanced Funding Requirements: Seven Conditions and Standards.

☐ Other. Please specify.

Please answer the following questions related to the functionality of any proposed replacement MMIS solution(s):

1. Regarding the MMIS financial subsystem:
    a. List the various components that make up your financial system. Examples include Accounts Receivable, Provider Financial Summary, Special Checks, Payouts and Recoupments, Remittance Advice and Provider Payments.
    b. Missouri currently executes financial cycles for provider payment on a bi-monthly basis with two or three weeks of claims included in each cycle. Please specify the financial cycle schedules such as weekly, bi-monthly, or monthly supported by your solution.
    c. Please describe functionality related manual payouts to providers calculated outside of claims processing including reimbursement programs based on non-claim data/activity such as a Nurse Assistant Training Program.
2. Regarding claims and Managed Care encounter processing and payment:
    a. Please describe the claims pricing models supported including pricing tiers, pricing history, fee schedules, etc.
    b. Please describe the payment models supported such as per member per month (PMPM) or capitation payments and the service types such as Managed Care, Non-Emergency Medical Transportation, and Healthcare Home that the payment models can be applied to.
    c. Please describe any enhanced payment models supported such as enhanced payments for specific providers as designated by the State such as state employed providers and safety net providers.
    d. Please describe similarities and differences in the adjudication of Fee For Service (FFS) claims and Managed Care Encounters and how the claims and encounters are differentiated in the system.
3. Missouri is a 209(b) State, which means that it must recognize a “spend-down” category of medical assistance for individuals whose income meets the eligibility standards after deducting expenses for medical care or allowing the participant to “pay in” the spenddown amount. Regarding the spenddown program:
    a. Please describe functionality in your solution supporting the tracking of expenses for medical care or participant pay-ins and applying eligibility after spenddown has been met.
    b. Does your solution have the ability to use Accounts Receivable to withhold provider payment of claims submitted for a participant that has not met their spenddown amount and applying as expenses for medical care?
4. Please describe any functionality supporting multiple provider specific taxes such as Missouri’s Nursing Facility Reimbursement Allowance *(*NFRA*)* and the Pharmacy Federal Reimbursement Allowance (PFRA) taxes.
5. Please describe how annual code set updates such as ICD-9 or HCPCS are applied to the system. Identify parts of the process that are automated or manual.

6. Please describe the recommended staffing model for ongoing support of the MMIS solution(s) assuming vendor hosted and supported solutions. Include a description of the model for operational development such as business rule development and modification, system configuration modifications, capture of additional data elements, updates to user portals and screens, updates to system parameters such as code sets or pricing tables, and modifications to electronic transactions.
7. Please describe how your solution supports the operational model including eligibility, claim adjudication, payment, and financials of a State Pharmacy Assistance Program.

Please answer the following questions regarding your Home and Community Based Services (HCBS) solution(s):

The MME currently utilizes a Home and Community Based Services (HCBS) web tool that provides case management functionality for participants who have had or are currently receiving Medicaid funded Home and Community Based services. As of August 26, 2014 there have been 110,177 participant cases opened in the web tool and 486,431 prior authorizations have been issued. The web tool provides screening, assessment, prior authorization, and case note entry for individual Medicaid participants who without HCBS would be facing institutionalization. MME staff and contracted providers access the web tool to complete the case actions necessary to authorize HCBS. The following types of HCBS may be authorized:

- State Plan Personal Care; and
- Waiver Services: homemaker, chore, respite care, adult day care, home delivered meals, personal care assistance, environmental accessibility adaptations, specialized medical equipment and supplies and case management.

Information related to eligibility determination and provider selection is received and made available in the HCBS Web Tool including:

- Medicaid demographic and eligibility information (date specific eligibility to include spenddown information and Medicaid eligibility code) from the MMIS system;
- HCBS provider information specific to the county of residence and the selected service from both the MMIS system and a Home and Community Services Provider Data base;
- Date of Death file, and
- File data from other MME solutions.

Information sent from the HCBS Web tool includes:

- Prior Authorizations for the delivery of HCBS (including newly created prior authorizations for delivery and reimbursement of services, changes to an existing prior authorizations and closing of authorizations) sent to the MMIS; and
- File data to other MME solutions.

1. If you are proposing MMIS solutions, would your solution be able to support the described functionality through out of the box configuration or customization?
2. Please describe how you would approach providing this functionality and the software solution(s) that would be utilized.

Please answer the following questions regarding multiple vendor management:

If you would be proposing MMIS solutions composed of separate modules covering different business functions manufactured by separate vendors (e.g. a claims processing tool from one vendor and a pharmacy benefit management tool from another vendor), please describe the following:

1. How will the modules be integrated/interfaced?
2. Will there be opportunities to share components of the technical architecture such as a business rules engine across the modules? If so, explain.
3. How would configuration management and software upgrade releases be coordinated?
4. Have you implemented these solutions as proposed for any other State Medicaid Agencies? If so, please identify the SMAs.

Please answer the following questions regarding the implementation and technical architecture of any proposed MMIS solution(s):

1. Regarding the project management and Software Development Life Cycle (SDLC) methodologies applied to development and implementation projects:
    a. Please describe the methodologies recommended and/or supported such as waterfall or agile.
    b. Please describe the roles of the State Project Management Office and State project staff.
    c. Please describe the testing approach. Do you employ the Model Office approach to testing?
2. What service levels does your solution support for Disaster Recovery of the MMIS; specifically what is the recovery time that your DR plan supports? Does your data recovery plan support a Hot Site, Warm Site, or Cold Site approach?
3. Please describe your organization's strategy for maintaining the code base for your MMIS solution(s), capturing and prioritizing functionality enhancement requests from customers, and developing and distributing releases. Include a description of your organization's approach to CMS mandated program changes such as ICD-10 or the X12 5010 transaction sets.
4. Please describe opportunities for your customers to collaborate on system enhancements, operational issues, and CMS-mandated program changes.
5. Please describe your organization's strategy for achieving compliance with the CMS Medicaid IT Supplement (MITS-11-01-V1.0) Enhanced Funding Requirements: Seven Conditions and Standards.
6. How does your MMIS solution protect data in transit and data at rest?
7. What metrics or other information (claim volume, amount of data, number of users, etc.) do you recommend be provided by the State of Missouri in a Request for Proposal (RFP) to allow a vendor to accurately size a deployment for a MMIS solution?

Please answer the following questions regarding hosting options and architecture for your MMIS solution:

1. Please describe the technical architecture for any MMIS solutions you would propose. What hosting options does your company support for these MMIS solutions? Do any of these options

include subcontractors? If so, what is the length/history of this partnership? Please consider the following parameters related to these hosting questions:

- All servers and data must be physically located within the United States and preferably within the State of Missouri.
- The MME is interested in leveraging cloud technologies as long as it can be implemented as a private cloud.
- Specific hardware and infrastructure should be dedicated to the State of Missouri to allow capacity to be added incrementally as needed. The State of Missouri's data must be stored in a defined location(s) and segregated from other clients' data.
- The necessary physical security and operational security processes/controls are in place to ensure no software, hardware, or data are vulnerable to being exposed to other clients/unapproved external entities.
- Describe your hardware refresh strategy to include recommended frequency/process to implement new hardware and to retire old hardware.
- Describe your software upgrade and patching strategy to include all elements of software utilized by implemented instances of your MMIS solution.

6.0 APPENDIX A – VENDOR RESPONSE COVER PAGE

Respondent's Name _____

Respondent's Physical Address _____

City _____ State _____ Zip Code (include 4 digit add on) _____

Respondent's Contact Person(s) _____

Phone Number & Area Code _____ Fax Number & Area Code _____

E-mail Address _____ Website Address _____

_____ _____

Authorized Signature of Respondent Data Signed

_____ _____

Typed Name of Authorized Signatory Title of Authorized Signatory

7.0 Appendix B – Acronyms and Abbreviations

Acronym	Definition
CAQH	Council for Affordable Quality Healthcare
CHIP	Children's Health Insurance Program
CICS	Customer Information Control System
CMS	Centers for Medicare & Medicaid Services
CMSP	Clinical Management Services and System for Pharmacy Claims and Prior Authorizations
COBOL	Common Business Oriented Language
CORE	Committee on Operating Rules for Information Exchange (CORE)
COTS	Commercial Off-the-Shelf
DFAS	Division of Finance and Administration Services
DHSS	Department of Health and Senior Services
DME	Durable Medical Equipment
DMH	Missouri Department of Mental Health
DR	Disaster Recovery
DSS	Department of Social Services
DUR	Drug Utilization Review
EDI	Electronic Data Interchange
EHR	Electronic Health Record
FA	Fiscal Agent
FFS	Fee For Service
HCBS	Home and Community-Based Services
HIPAA	Health Insurance Portability and Accountability Act
HIPP	Health Insurance Premium Payment
HIX	Health Information Exchange
ICD-10	International Statistical Classification of Disease and Related Health Problems version 10
IHE	Integrating the Healthcare Enterprise
ITSD	Information Technology Services Division
LTC	Long Term Care
MCO	Managed Care Organization
MECT	Medicaid Enterprise Certification Toolkit
MEDES	Missouri Eligibility Determination and Enrollment System
MHD	MO HealthNet Division
MITA	Medicaid Information Technology Architecture

Acronym	Definition
MMAC	Missouri Medicaid Audit and Compliance
MME	Missouri Medicaid Enterprise
MMIS	Medicaid Management Information System
MPR	Medication Possession Ratio
MTM	Medication Therapy Management
NDC	National Drug Codes
NEMT	Non-Emergency Medical Transportation
NFRA	Nursing Facility Reimbursement Allowance
OA	Office of Administration
PA	Prior Authorization
PACE	Program of All-Inclusive Care for the Elderly
proDUR	Prospective Drug Utilization Review
PFRA	Pharmacy Federal Reimbursement Allowance
PMPM	Per Member Per Month
PMS	Provider Management Systems
POS	Point of Sale
RFI	Request for Information
RFP	Request for Proposal
SDLC	Software Development Lifecycle
SFY	State Fiscal Year
SLR	State Level Registry
SMA	State Medicaid Agency
SOA	Service Oriented Architecture
SS-A	State Self-Assessment
TPL	Third Party Liability